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Training matters

Community psychiatry: senior registrars' views on training

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In view of the increasing emphasis on community psychiatry (Groves, 1990), there is much interest both locally and nationally as to what training experience is available or should be provided. So far, trainees have been bombarded by suggestions as to the essential content of training (e.g. Connolly & Marks, 1989), and enthusiastic accounts of experience gained have been published (e.g. Malcolm, 1989). Not surprisingly, anxiety has also been expressed (Haigh & Wear, 1989).

Nationally, the Collegiate Trainees' Committee Working Party has investigated the training implications of the shift to community-orientated psychiatry (Scott & Webb, 1988), and the Royal College of Psychiatrists has established a working group to report on these questions. In view of these developments and interest shown by the Oxford Regional Committee for Higher Psychiatric Training, the Regional Senior Registrar Committee decided to conduct a small survey of its members to illuminate the situation locally.

The study

All senior registrars and honorary SRs involved with adult psychiatry in the Oxford region at 1 February 1990 were sent a circular letter and a questionnaire regarding their experience of and views about community psychiatry. The letter explained that there was no accepted definition of community psychiatry, but that, in line with the Collegiate Trainees' Committee Working Party Report (Scott & Webb, 1988), respondents might consider four areas: links with general practitioners, management of patients at home, service planning, and evaluation of service changes.

The questionnaire contained six items:

(1) What experience in community psychiatry have you had during your period in higher training?
(2) How valuable (rewarding/stimulating/enjoyable) did you find it?
(3) What do you see as the main benefits and limitations of training in community psychiatry?
(4) What (if any) further experience would you like to gain in this area?
(5) Do you think that a 12-month placement in community psychiatry should be available on the SR rotation?
(6) Any other comments?

Findings

Twenty-eight questionnaires were sent out, and 20 replies were received (71% response rate). The responders included almost all the NHS SRs, and non-responders were more likely to be involved in research, although the numbers were too small to reach statistical significance.

Most (n = 17; 85%) trainees indicated that they had had some community psychiatric experience in higher training. Seven (35%) mentioned emergency home visits when on call. These would in fact be performed by all SRs participating in the rota: the under-reporting perhaps reflects differing conceptions of community psychiatry. Other experience mentioned included out-patient clinics at health centres (n = 6; 30%), GP liaison meetings (n = 6; 30%), non-urgent domiciliary visits either in general psychiatry (n = 6; 30%) or psychogeriatrics (n = 5; 25%), membership of a designated community team (n = 6; 30%), participation in planning of community services (n = 6; 30%), supervision and work with CPNs (n = 3; 15%), day care work (n = 2; 10%), and community work as part of a rehabilitation team (n = 1; 5%). Three trainees (15%) felt they had no experience of community psychiatry.

Comments as to the value of the experience were placed into five categories. The clear majority of trainees valued their exposure to community psychiatry. Eleven (55%) made unreservedly favourable comments, three (15%) were favourable although with reservations, two (10%) had mixed experiences, one (5%) expressed only unfavourable comments, and three (15%) made no comment.

Perceived potential benefits of community psychiatry included the value of home assessment and the resultant insights into the social context of the patient (n = 9; 45%), knowledge of the local GPs and

facilities (n = 8; 40%), preparation for future trends in psychiatric practice (n = 6; 30%), potential development of teamwork (n = 5; 25%), enjoyment and autonomy for the trainee (n = 3; 15%), a broad view of psychiatric morbidity (n = 3; 15%), better links with CPNs (n = 2; 10%), reduced need for hospital services (n = 2; 10%), and new ways of working (n = 2; 10%). Single trainees mentioned each of: patient preference, accessibility, and supervision experience.

Potential limitations mentioned were: lack of time and inefficiency (n = 5; 25%), lack of supervision (n = 5; 25%), isolation (n = 4; 20%), excessive ideology (n = 3; 15%), lack of consultant interest (n = 3; 15%), deskilling (n = 2; 10%), and lack of resources (n = 2; 10%). Potential limitations indicated by single trainees included boring meetings, diffusion of responsibility, practical organisation of training, (limited?) range of mental illness, possible exacerbation of problems, and possible delays in admission where this is indicated.

Interest was expressed in further community experience as follows: GP liaison (n = 5; 25%), community work as part of a placement in general adult psychiatry (n = 5; 25%), working with a well-established community team (n = 4; 20%), more experience of home assessment and treatment (n = 3; 15%), and planning and evaluation of services (n = 2; 10%). Single trainees wished for experience in a community mental health centre, full-time community psychiatry, more liaison with other groups, and more day care experience. Seven (35%) expressed no interest in further such experience.

Seven trainees (35%) thought unequivocally that a 12-month full-time attachment in community psychiatry should be made available to the SR rotation. Four (20%) disagreed equally unequivocally. Four (20%) were generally in favour but with reservations, and a further three trainees felt that a better alternative would be to increase the community component of general adult placements. One trainee thought such a placement was already in existence (in Buckingham), and another (not in an NHS post) abstained.

The most frequently made (n = 5; 25%) additional comment was the opinion that community psychiatry cannot be separated from general psychiatry, thus making it difficult to consider community training in isolation.

Comment

These data have several obvious methodological limitations. The questionnaire was brief and unstandardised, and the number of responses (a total of 10) was not large. However, the survey reflects the view of a representative majority of those in higher training in one region. Whether the attitudes expressed in the Oxford region are typical of the wider national picture is not known.

In this region, most SRs, NHS and honorary, felt that their higher training had provided experience in some aspect(s) of community psychiatry, although few had had a broad range of exposure. The questionnaire did not enquire about community experience gained in SHO and registrar posts, since many SRs had not been trained locally. An unsystematic impression is that, perhaps apart from out-patient clinics in health centres, there are fewer community opportunities in Oxfordshire for SHOs and registrars than for SRs.

Experience in community psychiatry was highly valued by the majority of SRs. Trainees seemed to vary in their definitions of community psychiatry, and several commented upon the inseparability of community from general adult psychiatry. Others felt that specialised training in community psychiatry should be made more available, though it was not clear precisely what was envisaged. In the future, at least two districts in the Oxford region will be adopting largely community-orientated services, so opportunities for predominantly community based training should be available. The responses received suggest that at least some SRs will be keen to work in such posts.

Finally, the survey highlighted the lack of an accepted definition of community psychiatry. There is perhaps also a need for the College to decide whether community psychiatry should exist as a separate specialty with its own training regulations.

References

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